

LABOR COMMISSION OF UTAH
Division of Industrial Accidents
P. O. Box 146610, Salt Lake City, UT 84114-6610
Phone: (801) 530-6800 Fax: (801) 530-6804

RELEASE TO RETURN TO WORK

Instructions: This form must be submitted when an injured worker's temporary disability compensation is less than 90 days. The form must be completed by the Adjustor after receiving a Physician's notification of release to return to full or light duty. The form must be submitted to the Reemployment Office within five (5) working days of the release date.

General Information		
Worker Name	Injury Date	
Address	Employer	
Phone Number	Social Security Number	Actual Number of Lost Work Days

☐**Released to Regular Duty**

Date _____

Permanent Impairments, if any:

☐**Released to Light Duty**

Date _____

Permanent Impairments, if any:

Anticipated Date of Release to Regular Duty:

Name of Person Submitting Form

Carrier Name

Phone Number

Date Submitted

cc: Industrial Accident Division

cc: Worker